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ELIMINATING ABSTINENCE IN IPLEDGE: A DERELICTION OF MEDICAL ETHICS?

Dear Editor:

In their recent article, Lowery et al[1] argue that iPLEDGE should remove abstinence as a contraceptive method, requiring individuals with reproductive potential to instead use medical contraception, regardless of sexual activity. We feel this change would be unlikely to significantly reduce fetal isotretinoin exposure, raises unacceptable ethical concerns, and may further limit access to isotretinoin—including for already marginalized patients.

While prescribed contraception has higher efficacy in preventing pregnancy than abstinence at the population level, this does not automatically translate into abstinence not being an appropriate strategy for certain individuals. For instance, prepubertal and/or precoitarchal adolescents, women who have sex with only women, many transgender

individuals, and individuals of some religious backgrounds do not engage in sexual behaviors (e.g., receptive vaginal–penile intercourse with a fertile partner) that can result in pregnancy. Certain age groups may be at lower risk of pregnancy regardless of sexual activity. Between Years 3 and 5 of the iPLEDGE program, only five unintended pregnancies occurred among patients older than 40 years of age, including no reports of unintended pregnancies among those choosing abstinence in this age group.[2] Additionally, some patients cannot utilize prescribed contraception due to medical, personal, or religious reasons.

Therefore, removing abstinence poses ethical issues. First, it compromises patient autonomy by forcing an individual into a potentially unnecessary intervention so as to receive a necessary medication. Patients should be able to make decisions about pregnancy-related risks and contraception with appropriate counseling and monitoring during isotretinoin therapy as is already the case with other teratogenic drugs. It also undermines the principle of nonmaleficence, as prescribed contraception is not without side effects. Aside from the known potential adverse effects of many hormonal contraceptives, including nausea, weight gain, vaginal spotting, breast tenderness, headaches, and potentially fatal hypercoagulability, such options for transgender individuals may interfere with hormonal gender affirmation, whereas some may even worsen gender dysphoria.[3] The feeling of coercion may irreparably harm the patient–physician relationship and sow distrust in the healthcare system. Patients and clinicians must jointly, through shared decision-making, weigh the risks of potential fetal exposure with the countervailing risks to the patients to reach an informed decision.

Finally, removal of abstinence may also disproportionately impact minorities and socioeconomically disadvantaged individuals. Such persons are already adversely affected by iPLEDGE, experiencing delayed initiation, increased treatment interruptions, and incomplete dosing.[4] This disparity would become especially relevant for transgender individuals for whom contraceptive alternatives are simply not acceptable options. Minority individuals may further experience disparities accessing contraception, especially as many dermatologists do not prescribe short-acting contraceptives and/or are unable to insert implantable contraceptives.[5]

Rather than removing abstinence, we can reduce rates of unintended pregnancies by better understanding who is actually using abstinence and who is not. We must work to improve our screening habits to actually understand a patient's sexual behavior and risk of pregnancy, and their understanding of abstinence and other methods of contraception. We must improve contraceptive counseling while mitigating barriers to adherence to abstinence or other contraceptive methods.[6] Enhanced integration of contraceptive management into dermatology education may facilitate more productive counseling and prescriber comfort with all forms of contraception. Such education would be beneficial not only in the context of isotretinoin but also for combined oral contraceptive pills as monotherapy for acne. Other efforts to improve contraceptive adherence and pregnancy prevention could include more robust emergency contraception counseling and access, allowing for isotretinoin initiation immediately after starting hormonal contraception, providing more refills with each short-acting contraceptive prescription, and leveraging electronic reminders. These potential solutions may help achieve iPLEDGE's proposed goal—to reduce fetal exposure to isotretinoin—in a more productive, ethical, and equitable manner.

With regard,

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